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ABSTRACT

This document reviews problems related to sexual activity among rural U.S. teenagers, successes and failures of teen sex education programs, and problems and needs specific to rural areas. In a recent poll, 89% of adults favored sex education in the schools and 73% supported making birth control information and contraceptives available in school clinics. The likelihood of a teenager becoming sexually active has less to do with socioeconomic status than with individual teens' values, goals, aspirations, and family environment in which he or she is raised. The primary causes of teens' contracting the HIV virus are ignorance, depression, being from a dysfunctional family, and poor school performance. Few sex education curricula address males and none describes strategies for using rural delivery systems. Successful teenage sexuality programs should deal comprehensively with the issues, last long enough to effect change, and involve students in the learning process. By itself, sex education is not a deterrent to teenage sex. The popular media encourage sexual activity and seldom address its accompanying responsibilities. Classroom programs must be supplemented by community-based efforts. Rural teens are as sexually active as their urban counterparts, but rural areas are less likely to offer HIV education to students. The prevalence of high-risk students in rural areas is high while resources are scarce. The need for effective programs to delay sexual activity and educate teens regarding the HIV virus has never been greater. Community approaches might be assisted by unique rural resources such as a tradition of neighbors helping neighbors and coperative extension services. (TES)

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NEEDS OF RURAL SCHOOLS REGARDING HIV EDUCATION

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ABSTRACT

A comprehensive literature review revealed that rural schools, although they tend to resist sex education, are experiencing growing numbers of IV drug users, pregnant teenagers, and sexually transmitted diseases. Through sexual activity and IV drug use, rural teenagers are placing themselves at risk for HIV/AIDS. The relationship between teen sexual behavior and the level of self-esteem has been well established, as have problems with traditional approaches to sex education. This article outlines factors in effective sex education programs and explains that sex education, in isolation, is not a deterrent. Problems specific to rural areas are emphasized in the article as are the necessity of rural-oriented approaches. Examples of viable methods of integrating HIV education into rural schools and community life are provided.

NEEDS OF RURAL SCHOOLS REGARDING HIV EDUCATION

National Recognition of Needs for Sex Education

The need for effective programs to delay sexual activity and to educate teens regarding the HIV virus has never been greater. U.S. teens under age fifteen are 15 times more likely to give birth than their peers in any other western nation (Buie, 1987). More than half of America's high school students report having sexual intercourse by the end of the twelfth grade. Over 25% of female teenagers (over 1 million each year) have experienced pregnancy (Kenney, 1987). Rates of sexually transmitted diseases (STDs) are higher in adolescents than in any other age group. In 1988, Shalwitz reported that 2.5 million American teens or 1 in 7 would be diagnosed with some type of STD (Shalwitz, 1988).

The problem is well recognized at all levels of the school system. For example, a survey by the Education Research Group reported that more than half of 716 administrators surveyed in a national study favored providing students with "birth control" as part of comprehensive school-based services. Yet 96% of U.S. school districts do not provide birth control, according to the survey. The vast majority of schools have not begun to develop comprehensive plans to deal with teen sexuality. School administrators simply have not wanted to broach a subject with such potential to inflame parents and communities.

In a recent national survey, school counselors stated that teen sexuality is part of the teenage lifestyle of risk-taking. Because sexual images and references are commonplace in today's society, educators view moral values as "crumbling" (Jolidon, 1989).

Parents also increasingly appreciate the need for schools to teach their children information concerning sexually transmitted diseases, including AIDS. In a recent Lewis-Harris poll (Harris, 1988), 89% of adults favored sex education in the schools. A full 73% supported making birth control information and contraceptives available in school clinics. Of course, these parents and many more also want their children to know that abstinence is the only completely safe form of AIDS prevention and to know what to do to avoid sex.

Students also recognize teen sexuality as a concern. Sexual issues were reported by 17% of junior high respondents in a national survey as their top concern (second only to drugs and alcohol) (*U.S.A. Today*, 1989).

The Relationship Between Teen Sexuality and Level of Self-Esteem

The likelihood of a teenager becoming sexually active and engaging in high-risk sexual behavior has less to do with socioeconomic status than individual teens' values, goals, aspirations in life, and the kind of family environment in which he or she is raised. Teenagers (especially girls) who see a positive future for themselves are less likely to become sexually involved at an early age, and are more likely to use contraception effectively if they do have sex. In 1982, a Northeastern University study also identified a correlation between early parenthood and academic ability. Older teenage females with poor basic skills were 2-1/2 times as likely to be mothers as those with average basic skills. Older teenage males with poor basic skills were 3 times as likely to be fathers. Among younger teens--those under sixteen--females with poor basic skills were 5 times as likely to become mothers as those with average skills (Kenney, 1987).

Teen sexuality is loaded with embarrassment, shame, fantasy, insecurity, urgency, external and often conflicting pressures, and other complicating factors. Thus, knowledge alone is generally not of much help in real life, spontaneous, emotionally laden situations. While only about one percent of teens is believed to use drugs intravenously (English, 1987; Paulk, 1987), a majority do use alcohol and/or other chemicals which can impair judgement (Rotheram-Borus, Coopman, & Paulk, 1989). Keller et al. (1988), found that sexual activity and drug use were positively associated in a teen cohort, regardless of age. The recent increases in teenage drug and alcohol use in the U.S. indicate the potential societal effects of these statistics.

All teens need real opportunities to grow into productive, self-sufficient adulthood. Only this will produce the motivation to delay sexual activity or to engage in only low-risk sexual behavior. Two of the most readily identified and important factors are education and employment opportunities. Although teen sexuality with high-risk behavior is a national

problem affecting all races and all economic strata, data clearly indicate that low income and minority groups--which typically can offer their young people fewer opportunities--suffer the most severe impact (CDF Reports, 1986).

Problems with Existing Sex Education Programs

Jorgansen (1981) and Paulk (1989) cited a formidable array of barriers to the effectiveness of teen sex education. These include teens' own levels of cognitive development, traditional sex role perceptions, parental lack of involvement with educational efforts, and the negative effects of mass media on the sexual socialization of youth. In the face of these and other barriers, it is not surprising that most teen sex education programs have been shown to be, at best, minimally effective (Kirby, 1984; Zelnik & Kim, 1982; Paulk, 1989).

Few curriculum sex education resources address males, and none describe strategies for using rural delivery systems. When males are approached, it is usually from an intellectual point of view (e.g., information receiving) vs. a behavioral or attitudinal point of view. According to the Mens' Reproductive Center, the relatively few male-oriented projects across the U.S. usually have not lasted more than 3 years. Funding agencies typically either do not fund them or they prioritize care programs for pregnant teens and do not re-fund male-oriented programs.

Success Factors in Teen Sex Education Programs

Paulk (1985) found three factors which appear to facilitate the success of teen sexuality efforts. First, the program should be long enough to effect significant, lasting change. Second, the program should be comprehensive, dealing with as many as possible of the varied issues surrounding sexual risk-taking. These issues include sexual and contraceptive knowledge, self-esteem, decision-making skills, and assertiveness skills. Finally, the program should involve students, both intellectually and emotionally, in the learning process (Helge & Paulk, 1989).

Most teens wait one year after becoming sexually active before seeking medically supervised contraceptive care (Kenney, 1987). Shortening the delay between the first

intercourse and use of effective contraception could significantly reduce the chances of teens contracting the HIV virus.

Significantly impacting sexual risk-taking behavior is difficult, and designing and implementing effective programs requires commitment and creativity. Effective programs require prevention and care services involving every available and appropriate community agency. Male roles must be addressed in terms of sexual issues and contraception. Males and females must understand that to avoid contracting the HIV virus, they must abstain from sex or use contraception consistently and effectively. Many youth will be most comfortable abstaining from sex. Others must learn the risks of sexual behavior, what to do to abstain or contracept, and how to manage social situations so that they can.

Studies have clearly indicated that youth who engage in open, frank communication with their parents (less than 15% of all adolescents) are more likely to succeed in delaying intercourse and/or have protected intercourse. The family life education these youngsters receive in schools, churches, youth groups, and medical facilities reinforce and enhance their knowledge of "safe" sexual practices. Youth service providers including doctors, nurses, therapists, probation officers, educators, coaches, and youth group leaders must continue to support and educate these young people while addressing the needs of the other 85% (Shalwitz, 1988).

Program planners must remember that the youth services providers are themselves heterogeneous. Some are comfortable discussing issues related to sexuality, sexually transmitted diseases and HIV infection, condom use, and drugs, and some find these topics unacceptable and disquieting. Therefore, each worker and agency must examine its scope and limitations in dealing with prevention. Workers must be continuously trained and supported.

The last decade's experience with sex education has glaringly revealed that didactic "one shot deals" are ineffective in changing behaviors. Successful prevention strategies are most likely to succeed if the following components are included (Shalwitz, 1988).

* Information and messages communicated to youth must be accurate, brief, explicit, and direct as well as consistent and repetitive. Ambiguous and judgmental terminology such as "sexually active," "bodily fluids," and "promiscuous," should be avoided. Due to the serious nature of the material, humor and engaging presentations are often most effective. Messages may need to be articulated multiple times before being heard. Thus, service providers must be patient and tenacious.

* Youth will respond in a more positive and interested manner when they hear a message from a person they trust, whether it be a parent, friend, or counselor. Therefore, it is of utmost importance that service providers understand the social norms and values of the target population as well as their HIV-related risk factors. Activities and materials must be linguistically, culturally, educationally, and developmentally appropriate and sensitive. Audio-visual aids which represent the target population make the issues presented more believable and realistic.

* AIDS/HIV infection must be presented within the context of the broader societal/family life issues young people experience. Education must incorporate values clarification, self-empowerment and skills development, particularly in the areas of communication, decision-making, and assertiveness training. These features should be threaded through a comprehensive family life education scheme which should include but not be limited to the following: anatomy and physiology; sexual development; cultural values and norms; pregnancy, STDs, HIV infection, contraception; parenting; violence/abuse; substance abuse; racism and homophobia; and self-esteem development. It is important to communicate the interrelationship of high-risk behavior and sexually transmitted conditions (pregnancy, sexually transmitted diseases, and HIV infection).

* Youth and parents should be incorporated into the design and implementation of activities and programs. Peer counselors, parent trainers, and indigenous outreach workers should be adequately trained and utilized wherever and whenever feasible, in schools and community-based sites. It is of utmost importance to capitalize on the positive power of peer pressure and support.

* All administrators and staff working with youth should be trained and educated at regular intervals regarding STDs/HIV infection, and other relevant issues. Staff should also be knowledgeable with the language and lifestyles of the youth with which they will interact. Youth service providers should be given the opportunity to practice discussing these sensitive matters by role play and other methods.

* Educational and counseling activities must offer a flexible assortment of alternative methods, behaviors and options which achieve the primary goals of eliminating further spread of STDs/HIV infection. Activities will need to be modified according to the service site (e.g., schools, detention centers, 4-H clubs, grange clubs, extension agencies, etc.). There is not one standard "AIDS rap" that can serve as a model for information dissemination.

* Schools and/or non-school-based prevention activities must be integrated into a comprehensive, coordinated service delivery system to youth. Appropriate and accessible medical, psychiatric, and support resources should be identified for the spectrum of youth who are low- to high-risk for HIV infection, uninfected, or diagnosed with AIDS. Ideally, these resources should have a primary interest in providing affordable, confidential, developmentally appropriate services to young people who are culture and language sensitive.

* Service sites or staff persons/clinicians who opt to disseminate condoms should never assume that a youngster knows how to correctly use them. Condom education, whether done individually or in groups, is more effective with a visual demonstration, using anatomically correct models rather than an oral presentation.

* Prevention and counseling programs should be evaluated for effectiveness and modified according to the latest information and the composition of the targeted population.

(Shalwitz, 1988)

Why Teenage Sex is Common

Studies have indicated that sex is not the main consideration in teenage dating. More important to boys is companionship and to girls is communication. Teens appear to have a difficult time separating sexual affection from other kinds of affection (*U.S.A. Today*, D-1, January 20, 1989). It is essential that schools teach communication skills and the difference between intimacy and sex.

Clearly, the primary causes of teens' contracting the HIV virus include ignorance, poor sex education, poor school performance, depression, low self-esteem, being from an alcoholic/dysfunctional family or from a broken home, lack of parental supervision, school adjustment problems (particularly early grade problems or transition problems from elementary to junior or senior high school), or being a school dropout (Samels, 1989). Many of these factors are interrelated and some (such as poor self-esteem, living in a dysfunctional family, and poor academic performance), may be causal (Samels, 1989; Helge, 1988).

Sex Education, in Isolation, is not a Deterrent

The American culture is greatly influenced by the popular media--television, videos, movies, radio, and magazines. Most media vehicles promote sex as romantic and exciting but seldom address the responsibilities of sexual relationships, contraceptives, or the potential of

contracting the HIV virus. Many U.S. teenagers have been reared in a single-parent household or in families where both parents work. Many have been left to fend for themselves at an early age, and their role models are images they see on television and videos. Many students are afraid their parents will think ill of them if they discover that they are using birth control. Thus, they continue to take unnecessary chances.

Sex education is not a sure deterrent to teenage sex or teens contracting the HIV virus. Research has repeatedly shown little correlation between participation in a *unit* on sex education and the level of teen sexual activity (Buie, 1987). Simply incorporating a unit on HIV education into other coursework may increase students' knowledge, but it rarely changes behavior (*U.S.A. Today*, D-1 & D-2, May 16, 1989). HIV education must be expanded beyond a one or two week session in high school to become, instead, part of a twelve-year learning program with a broader agenda that includes encouraging young people to set long-term goals and to think beyond the present.

Research has clearly indicated that school sex education programs do not lead teens to delay sex, use birth control, or avoid pregnancy. Teen's sexual mores are molded instead by television, films, music, advertising, peers, and adult models (*U.S.A. Today*, D-1, April, 1989). At most, schools typically offer a few weeks of scattered sex education lessons, and the majority of those teaching these lessons are not qualified personnel. Because sex is not an isolated behavior, effective sex education must be part of an overall health approach (*U.S.A. Today*, April, 1989). Classroom programs must be supplemented by community-based efforts involving parents, churches, youth groups, and the media.

Problems Specific to Rural Areas

Two-thirds (67%) of U.S. schools are rural. This is a vast constituency. According to a number of surveys (*U.S.A. Today*, D-1, January 20, 1989; Jolidon, 1989), rural teens are as sexually active as their non-rural peers. Yet rural schools frequently view AIDS as an urban gay men's problem and are the least likely to offer HIV education to their students. Frequently, rural communities with traditional value systems resist sex education. Schools

which do provide it frequently lack appropriate curriculum or resources to secure such materials. Many rural school districts lack qualified health educators or other teachers who are comfortable with sex education and being known as the community "sex educator." Many rural schools do not offer health education, and those that do frequently limit it to 20-40 minutes per week. Because of this time limitation and community resistance to sex education, it is not usually integrated into health education as it typically is in non-rural schools.

Even with HIV education mandated by many states, rural sex education is typically minimal. For example, a national survey of 100 randomly selected rural schools in the U.S. indicated that while 80% of respondents stated that their schools provide some form of mandated HIV education, 90% permit parents to excuse their children from this education (Helge & Paulk, 1989). Most programs (59%) took place in one day or less, and most HIV education programs are provided in upper rather than lower grades. Thus, sex education was of an even shorter time span than in many non-rural areas although it was oriented specifically toward HIV education, because of state mandates (Helge & Paulk, 1989). The survey indicated that most of the programs did not meet the criteria described earlier as essential for an effective sex education program.

The prevalence of at-risk students in rural areas of the U.S. is high (Helge, 1988). Rural areas typically have disproportionate percentages of students from poor families. Many rural communities are composed of Hispanic migrants and other non-English speaking populations or other minorities such as southern Blacks and Native Americans. Many of the factors associated with teens' contracting the HIV virus such as poverty, dysfunctional families, poor economy, isolation, alcoholism, lack of parental support, high dropout rate, low student and adult aspirations, low peer and parental expectations, lack of economic opportunities, and limited available social activities, are more prevalent in rural areas (Helge, 1988).

Successful role models are frequently limited--particularly successful female role models. There is typically little, if any, qualified counseling concerning personal development issues or individual counseling concerning sexual issues. Health and mental health resources are

frequently absent in rural areas, particularly those that are geographically remote or isolated. Community mental health resources are also inadequate, and the majority of rural schools do not employ school counselors, primarily for financial reasons. Psychologists and counselors, when available, frequently spend a majority of their time conducting standardized tests or designing class schedules, vs. counseling individual students or groups (Helge, 1988).

Sexual activity frequently begins in elementary school, especially in impoverished areas. Rural schools do not have the resources of urban and suburban schools for school-based programs (e.g., family planning clinics). Population sparsity, funding difficulties, and traditional rural attitudes generally prohibit this. In fact, data collected from rural schools field-testing HIV education curriculum modules for the National Rural and Small Schools Consortium HIV education project indicated that they only selected curriculum that was "appropriately traditional, conservative, and emphasized abstinence." Most rural districts were offering sex education only because of state HIV education mandates.

A majority of rural communities do not have planned parenthood and related agencies geographically accessible to them. Youth-serving agencies such as boys clubs, YWCAs, and YMCAs are nonexistent in many rural communities. Established agencies such as cooperative extension (county agricultural agencies) or 4-H clubs are generally not tapped by schools as rural sex education resources. Male reproductive health resources are virtually unknown in rural America.

Most grants or other programs available to rural areas emphasize services to pregnant teens vs. sex education or AIDS prevention. Research regarding school-based clinics that provide birth control have revealed a decline in teenage pregnancy (*U.S.A. Today*, April, 1989). Such clinics follow an urban model. There are simply not enough students in sparsely populated, isolated rural areas to merit such an approach. In fact, a comprehensive literature review revealed that most innovative pregnancy prevention projects are metro-oriented and are not easily adaptable for sparsely populated rural areas. (E.g., New York City and New Orleans' traveling theaters, and Oakland's programs of meeting boys at major sports events

and taking them to planned parenthood clinics). While the National Urban League sponsors programs in more than 70 cities to prevent and deal with teen sexuality and over 100 schools across the U.S. have school-based clinics, rural areas generally lack such programs.

Rural-Oriented Approaches

Rural-oriented approaches to HIV education are definitely needed. Strategies for creating any type of change in rural areas are best implemented by local personnel who feel that the change was at their initiation or, at least, addresses a perceived need of theirs. Significant change will most likely occur with approaches that are holistically and experientially based, and take the time to process information, versus those that assume that cognitive "one shot" curriculum approach will produce child change.

As reported by Lloyd Kolbe of the Centers for Disease Control (*U.S.A. Today*, D-2, May 16, 1989), even though national surveys have clearly indicated that teens know the basic facts about AIDS, they are not doing much to protect themselves. HIV education has to be more than information transmission. It must include decision-making, communication skills, and self-esteem education. Students with high self-esteem will care enough about themselves and others to make decisions to improve their future rather than unnecessarily place themselves at risk.

It is clear that self-esteem education must be integrated with HIV education. This cannot occur within a few hours. Accomplishing this in conservative, under-funded rural schools is an exciting challenge.

The Rural Schools HIV Education Project, funded by the Centers for Disease Control to the National Rural and Small Schools Consortium (NRSSC), is using approaches to integrate HIV education and techniques to enhance self-esteem. This design is necessary so that students have both the strength and the knowledge to abstain from early sex or, at least, to experience safe(r) sex. Approaches are field tested with a pilot student group. Pre- and post-test data are gathered from the students, their teachers, related administrators, and the group facilitators regarding HIV education and self-esteem enhancement. A trainer-of-trainers

session is taught at the annual NRSSC and ACRES national conferences and during courses offered at Western Washington University, where NRSSC is housed. During such sessions, participants receive basic HIV education and design a master plan for implementing HIV education and self-esteem enhancement projects in their home districts. They also hear content regarding rural-based strategies for implementing HIV education and discuss other information gained from working with the pilot project.

HIV education approaches that will be successful in rural areas will include curriculum palatable to local community values and mores, sex education support from local community organizations and parents, educational approaches consistent with community values, alternate social activities and reward systems for teens, qualified sex educators or other teachers who are comfortable with sex education and with being known in the community as a sex educator, and successful role models.

Successful program planning will account for the fact that rural communities are extremely heterogeneous depending on their economic base and social cultures. Approaches to be used must incorporate career counseling, vocational training, and involve churches, parents, youth groups, and the media. Rural communities do have a number of unusual resources that generally have not been effectively used. For example, since citizens in small rural communities typically care about each other and neighbors help neighbors, extended families and existing outreach systems should be used. This would include the cooperative extension service (county agricultural agencies), 4-H, public health educators, and outreach personnel such as bookmobile staff, mail carriers, and meter readers.

An illustration of the unique strategies required to implement HIV education in rural schools is the involvement of county extension personnel. They are "out and about" in the local community, know everyone, and are selected for their positions because they are respected citizens and thus listened to. Other examples of parties to be educated and involved for effective HIV education programs are extended families (more prevalent in rural areas), and other "natural outreach providers." These providers may include public health agency

personnel, meter readers, mail carriers, bookmobile personnel, and others who have a natural communication system that is highly effective. The local communication and power structures must be acknowledged and effectively used. (E.g., the one gas station attendant in a remote rural area talks to lots of folks each day and can change opinions. The clerk at the one grocery store in a rural area is another resource.)

Most such individuals, according to NRSSC and ACRES on-site studies, are well respected in the local community and can make or break a project. It is also critical to involve local social organizations no matter how few and how small they may be. For example, the garden club could show a Red Cross HIV education film as a program. The 4-H club, a county extension meeting, the Grange organization, VFW, the wranglers riding club, and local churches could do the same.

Any social organization, informal or formal, can be a vehicle for implementing HIV education. If rural citizens feel that the project is relevant to the community and if they are involved in designing and implementing the project, it will be more likely to be implemented. Such groups are essential for school HIV education programs to be successful.

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